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September 22, 2004

To: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Yvonne B. Burke
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: David E. Janssen
Chief Administrative Officer

SACRAMENTO UPDATE

Legislative Analyst Issues Report on California's Budget

The Legislative Analyst's Office (LAO) today issued its annual report, California Spending Plan 2004-05. The report, which provides a detailed description of the adopted budget and budget related legislation, is available on the LAO web site at http://www.lao.ca.gov/2004/spend_plan_04/0904_spend_plan.pdf. Of particular interest is the LAO's assessment that, absent further corrective actions, the State will continue to face budget shortfalls in the coming years. The LAO, which had earlier estimated the out-year shortfalls to be roughly \$6 billion in FY 2005-06, and \$8 billion in FY 2006-07, suggested that end-of-the-session budget actions only added to the size of the problem. While there is around \$3.5 billion remaining in one-time funds from the proceeds of the deficit bonds, significant actions will be needed to eliminate the structural deficit and bring future budgets into balance.

Medi-Cal Hospital Financing

Late yesterday, the California Health and Human Services Agency and the California Department of Health Services released to the Disproportionate Share Hospital (DSH) Task Force, of which the County is a member, the attached concept paper which outlines proposed modifications to Medi-Cal supplemental hospital payments. The concept paper is consistent with the Administration's stated desire, expressed in a number of meetings with the DSH Task Force, to reduce and/or phase-out the use of

Intergovernmental Transfers (IGTs) in the Medi-Cal DSH and SB 1255 programs. The Administration is proposing to replace IGTs with an alternative financing model known as Certified Public Expenditures (CPEs) which would be made by county and University of California hospitals. The concept paper outlines a five-year 1115 waiver approach which would replace the existing Selective Provider Contracting Program (SPCP) waiver, and "the expiring Los Angeles County waiver with a statewide waiver that provides federal reimbursement for counties that expend public funds to provide services to indigents."

Today, Administration officials discussed the concept paper on a conference call with the DSH Task Force, and indicated their intent to share it with officials from the Centers for Medicare and Medicaid Services (CMS), in meetings next week in Washington, D.C. Administration officials noted that they are seeking reaction to the CPE concept in their upcoming meeting with CMS, and would meet with the DSH Task Force afterward to report results and discuss next steps.

Because the Administration's concept paper does not include any financial estimates, it is very difficult to ascertain whether the approach is viable, how it impacts provider payments, and, specifically for the County, the Department of Health Services' fiscal forecast. Consequently, the DSH Task Force determined it was unable to provide the Administration with an endorsement of the proposed approach. Additionally, the DSH Task Force conveyed continuing concerns including whether the proposed approach addresses California's inadequate Medicaid share, the pitfalls of trading IGTs for CPEs, and whether the Administration's concept promotes safety net hospital stability.

Status of County-Interest Legislation

County-supported AB 578 (Leno), which would create the Electronic Recording Delivery Act of 2004 which authorizes counties, upon approval of their Board of Supervisors and certification by the Attorney General, to permit the electronic delivery, recording, and return of records that are instruments of reconveyance, substitutions of trustees, or assignments of deeds, was signed by the Governor on September 21, 2004. Because this measure has an urgency clause, it becomes effective immediately.

County-supported AB 858 (Goldberg), which would prohibit public schools from using the term 'Redskins' as a school or athletic team name, mascot, or nickname beginning January 1, 2006, was vetoed by the Governor on September 21, 2004. The bill would have exempted schools with enrollment boundaries that include a portion of Indian reservations provided that the tribe having regulatory jurisdiction over the territory within the school's enrollment boundaries authorized the use of the team name, mascot or nickname. In his veto message, the Governor stated that existing law already affords local school boards general control over all aspects of their interscholastic athletic policies, programs, and activities and decisions regarding athletic team names, nicknames or mascots, and authority should be retained at the local level.

County-supported AB 1896 (Horton), which would affect the Agricultural Commissioner's contracts with the State for insect detection services by requiring the County to make Agricultural Inspector Aides, for whom there is year-round work, permanent employees, was signed by the Governor on September 21, 2004. The measure restores \$380,000 of \$550,000 in funding for the FY 2004-05 budget that was previously vetoed by the Governor. Additionally, while the law provides funding for FY 2004-05 only, we understand from the author and labor representatives that the Governor's Office has committed to include the necessary funding in the FY 2005-06 proposed budget that is presented to the Legislature in January.

We will continue to keep you advised.

DEJ:GK
MAL:JF:JR:EW:ib

Attachment

c: Executive Officer, Board of Supervisors
County Counsel
Local 660
All Department Heads
Legislative Strategist
Coalition of County Unions
California Contract Cities Association
Independent Cities Association
League of California Cities
City Managers Associations
Buddy Program Participants

SUMMARY OF CALIFORNIA'S PROPOSAL FOR
A NEW SECTION 1115 WAIVER TO REPLACE
THE CURRENT SELECTIVE PROVIDER CONTRACTING PROGRAM
AND LOS ANGELES COUNTY FUNDING WAIVERS
September 21, 2004

This document summarizes the proposal of the State of California for a section 1115 waiver effective July 1, 2005, that will address how the Medi-Cal program reimburses hospitals over the next five years.

The California Medicaid program (Medi-Cal) is at a crossroads. The principal authorizations that govern funding of some of the major elements of the program are expiring and must either be renewed, modified or replaced. Programatically, the state is in the midst of a major redesign study, which has engaged stakeholders, advocates and government officials over the past several months. The relentless upward pressure on program costs and the increasing demand for services are occurring during a period of stagnant state revenues and severe competition from other worthy claimants for state support.

It is not that the program is not operated efficiently. Medi-Cal is by far the largest state Medicaid program in the nation; however, spending in the program, per capita, is the lowest in the nation.

California also faces the unique problem, not of its own making nor one that it has the capacity to solve, of a large volume of uninsured people who rely for health care needs on the public programs, and are an especially serious issue for the state's largest public service providers.

It is vital that California establishes a stable and sustainable financial structure for Medi-Cal that will accommodate whatever redesign changes, which emerge from the process that is currently underway, so that the program can operate with maximum efficiency, and provide the greatest possible access to health care.

The section 1115 waiver application that the state is seeking, summarized below, represents the State's best judgment as to how to achieve that overall goal.

Measures of Success

The proposal is designed to accomplish the following significant goals related to the reimbursement of hospitals:

- Ensuring and addressing federal concerns about how Medi-Cal finances its payments to California hospitals;
- Preserving the current levels of federal and non-federal contributions to the program;
- Ensuring that the services provided by the public and private safety-net hospitals continue to be reimbursed at the same overall net level as under the current method, relative to the volume of service provided;
- Providing a secure, five-year financing package;
- Developing opportunities for funding growth in the program;
- Confirming the State's ability to access its full federal Disproportionate Share Hospital (DSH) allotment;
- Ensuring a clear understanding and agreement of the cost-finding methodologies that will be permitted by CMS and the interim financing and cost-reconciliation requirements that will be necessary to implement the State's proposed hospital financing mechanism;
- Ensuring a clear understanding and agreement on the treatment of costs associated with serving the undocumented population; and
- Extending the existing hospital financing mechanism until June 30, 2005, to assure time to transition to the new financing system.

In order to achieve these goals, the proposal envisions:

1. Continuation of the Selective Provider Contracting Program (SPCP).
2. Expansion of Medi-Cal to incorporate, by waiver, the public indigent care system currently operated in Los Angeles County and many other counties throughout the State.
3. Modification of the basis for reimbursement of hospitals so as to utilize public expenditure certification as the primary means of funding fee-for-service and DSH payments to public safety-net hospitals, with the continued use of some "protected" intergovernmental transfers (IGTs) considered permissible by CMS.

4. Continuation of the current upper payment limit, notwithstanding shifts in service delivery from fee-for-service to managed care.
5. Flexibility in financing so as to be able to accommodate whatever changes in the Medi-Cal delivery system emerge from the current and ongoing Medi-Cal redesign efforts.
6. Opportunities for program growth during the waiver period.

A. Continuation of Selective Provider Contracting Program

The Selective Provider Contracting Program (SPCP), which operates under a section 1915(b) waiver, has proved its utility and has met the goals established when the waiver was adopted and extended.

SPCP contemplates cost savings through negotiated rates with hospitals willing to serve Medi-Cal patients under more economical rates in return for some assurance of a steady volume of Medi-Cal business. Fee-for-service payments have been contained as a result of the contracting process, saving both federal and state funds.

SPCP has been in existence for over 20 years and has reached maturity as a program. There is no longer any necessity for review of it every two years. Accordingly, the State is seeking to incorporate the program into a five-year waiver under section 1115. There is substantial demonstration value to justify this approach, because it includes major changes in the method of paying for hospital services, the ability to extend primary care services to the medically indigent, and the accommodation of sufficient flexibility to enable the State to introduce cost efficiencies into its service delivery system over time.

B. The Medically Indigent Care Program

Many counties, including Los Angeles, have substantial indigent care programs supported by state and local tax dollars. In Los Angeles, ambulatory services for the indigent population also have been supported by federal funds under the Los Angeles County 1115 waiver, which is scheduled to expire on June 30, 2005.

The State will seek to replace the expiring Los Angeles County waiver with a statewide waiver that provides federal reimbursement for counties that expend public funds to provide

services to indigents. Covered services would include inpatient and outpatient hospital services, clinics, physician services provided in hospitals and clinics, and other ancillary services such as durable medical equipment. As with the current Los Angeles waiver, while funds expended for indigent health care would be eligible for federal financial participation, there would be no entitlement or set benefit package.

The waiver will help secure the county-based indigent care programs that are currently in place. Those county-based systems are continually threatened by proposed and actual reductions in available public resources, even as the number of uninsured continues to grow. The assurance of federal participation in continued funding would enable counties to continue to operate their indigent care programs, and to re-balance those programs towards primary care and other ambulatory services and away from reliance on hospital emergency rooms.

C. Proposed New Hospital Reimbursement Plan

Currently, California's hospital reimbursement plan is based on the following principal components:

1. Fee-for-service payments at the SPCP negotiated rate or the state plan rate for inpatient hospital services.
2. Supplemental payments to public hospitals based upon the aggregate upper payment limit under federal regulations for inpatient hospital services, for state-owned and operated hospitals (which would include the University of California hospitals) and for non-state public hospitals (which would include the Los Angeles County hospitals and those of twelve other counties), funded through IGTs from public entities to the State.
3. Supplemental payments to public hospitals on a CPE basis for outpatient hospital services.
4. Payments to hospitals from managed care organizations for services provided to managed care enrollees.
5. Disproportionate share payments to private and public hospitals that utilize the entire federal DSH allotment and that are funded by IGTs from public entities.

All of the foregoing elements of the current reimbursement plan have been reviewed and authorized by CMS.

While California believes that its existing reimbursement system has served both the state and the federal government well and meets all federal and legal requirements, it understands that CMS is insistent upon states eliminating certain types of funding practices and that CMS regards some of California's current methods as the kind of funding practices it seeks to eliminate.

California is prepared to modify its funding practices, provided that it is able to utilize alternative financing methods that are consistent with our identified goals, which will yield the same degree of federal support and are deemed permissible by CMS. The State is developing such a system that it believes to be fully consistent with Medicaid law and current CMS policy. California seeks incorporation of that approach into its 1115 waiver, in order to provide assurance over the five-year waiver period that its reimbursement system will not be subject to federal challenge.

The elements of the proposed reimbursement system are as follows:

1. Inpatient fee-for-service reimbursement would be cost-based and effected through certified public expenditures (CPE) by the hospitals in the University of California system and the public hospitals in 13 counties (including Los Angeles County), which participate today in the SPCP and the supplemental payment program. The state would distribute to the hospitals periodically the federal share of the expenditures made in support of service to Medi-Cal-eligible inpatients.
2. In addition, the participating public hospitals would be eligible for supplemental payments up to the applicable upper payment limit under federal regulations, which would be computed separately for state-owned and operated hospitals (which would include the University of California hospitals) and for non-state public hospitals (which would include the Los Angeles County hospitals and those of twelve other counties).
3. To accommodate anticipated changes that would make the service delivery more efficient without causing a reduction in available federal funds, California proposes to modify the manner of establishing the upper payment limit to take into account all inpatient hospital services, whether

delivered on a fee-for-service or managed care basis. With five county organized health systems created by federal law operating in eight counties, California has unique circumstances that merit revisions in this waiver. The proposal utilizes the current upper payment limit calculation as the base, subject to adjustments to reflect changes in the Medicare level of hospital reimbursement. This approach would allow for supplemental payments, on a CPE basis, to cover the shortfall in reimbursement received by the hospitals for serving Medi-Cal patients in a managed care setting.

4. The public hospitals would qualify for DSH payments, which would also be reimbursed on a CPE basis to the extent of uncompensated care costs not utilized in connection with the supplemental payments. The federal share of these payments would be pooled, and distributed by the State among the participating hospitals.
5. In some cases, as allowed under federal law, public hospitals would receive additional DSH payments above 100% of their uncompensated care costs, paid from state and federal funds. These payments would be utilized as necessary to maintain the current levels of reimbursement for these hospitals. While California will use its entire federal DSH allotment, the State anticipates that it would use only a small portion of the "room" between 100% and 175% of uncompensated care costs, which is the authorized ceiling for DSH payments to public hospitals in California.
6. Private hospitals would receive supplemental payments equal to the current level of supplemental and DSH funding; however, rather than continue to receive funding that is designated as DSH, all of their payments would be designated as supplemental. Because private hospitals cannot use the CPE approach, they would receive both the federal and non-federal share for all Medicaid reimbursement. This element would ensure continued support for those private hospitals that are essential to maintaining the safety net for needy Californians.
7. California would continue to use IGTs that meet CMS criteria as "protected" transfers from public entities as a funding source for payments under the proposed programs. These IGTs may be used, for example, as the non-federal share for payments to private hospitals or for DSH payments to public hospitals above 100% of uncompensated care cost.

8. As described in Part B, above, county expenditures for indigent health care would be eligible for federal financial participation, at cost, using a CPE approach.

In addition, California proposes to reimburse hospital-based physicians and ancillary services in public safety-net hospitals at cost, on a CPE basis. This will enable the hospitals to certify their current expenditures for the costs incurred in keeping both primary and specialty care physicians to assure access.

Furthermore, in addition to the proposal to bring the county indigent care program under Medi-Cal, the State is evaluating reimbursing public non-hospital clinics at cost on a CPE basis, consistent with the recently adopted change in reimbursement for hospital outpatient services.

D. On-going Medi-Cal Redesign Initiative

California has been considering Medi-Cal redesign ideas for several months. Earlier this year over a several month period, the Department of Health Services conducted a series of stakeholder meetings at which numerous proposals were advanced and discussed. Since that time the State has continued to study a number of possible program options. It expects to present a redesign proposal to the California Legislature in January 2005. Depending on the overall outcome of redesign, at a later date, California may seek to amend the waiver.

As part of that process, the State is considering various possibilities for managing the care of Medi-Cal participants who are not currently in a managed care setting. The goals of redesign are to bring about operating efficiencies to the health care delivery system, assure better health outcomes for patients, and to moderate the cost growth in the program for both the state and federal governments.

E. Budget Neutrality Issues

The State contemplates being able to maintain its hospital reimbursement system and incorporate the cost of the public indigent care system through use of federal funds based on the currently available federal resources for support of the State's Medi-Cal program. Those resources include the federal share of reimbursement for inpatient and outpatient services to the affected public hospitals up to the federal upper payment limits

and the State's DSH allotment. Bringing these resources under an 1115 waiver provides the State greater flexibility in utilizing the resources in the best possible way to ensure a viable, economic and responsive health care system.

It will also be necessary to reach agreement with CMS on appropriate indices for use in projecting cost growth over the life of the waiver, and for projecting the UPL growth based on Medicare payment principles. Establishment of a secure basis in advance for determining these limits will make it possible for the State to plan a coherent system that does not embody a risk of after-the-fact recalculation of key elements in the funding formula.

This waiver must ensure that California have sufficient funding on an ongoing basis to address current costs, projected growth and unforeseen circumstances.